

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010235</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/19/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>HARBOUR ASSISTED LIVING OF FORT WAYNE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3110 E COLISEUM BLVD</b> <b>FORT WAYNE, IN 46805</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00193196.</p> <p>Complaint IN00193196 - Substantiated, no deficiencies related to the allegations were cited.</p> <p>Survey Dates: February 18 &amp; 19, 2016</p> <p>Facility number: 010235 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 53 Total: 53</p> <p>Census payor type: Other: 53 Total: 53</p> <p>Sample: 3</p> <p>Harbour Assisted Living of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00193196.</p> <p>QR was completed by 99993 on 02/19/16.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE